DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435086	A. BUILDING _____ B. WING _____	C 09/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW HEALTHCARE CENTER	611 EAST 2ND AVE FLANDREAU, SD 57028

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted on 9/6/23. The areas surveyed were falls with injuries, care planning, and professional standards. Riverview Healthcare Center was found not in compliance with the following requirements: F609, F657, and F658.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the	F 609	1. Resident #1 has been discharged from the facility. All residents have the potential to be affected. 2. The ED and DNS were educated by the DDCO (Divisional Director of Clinical Operations) prior to 10/1/2023 on reporting of allegations/suspicions of abuse/neglect. 3. The DDCO will review progress notes weekly times four weeks and monthly times two months to review potentially reportable events. The DDCO will bring the results of these audits to the monthly QAPI meeting for review and to determine to continue or discontinue the audits.	10/15/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Tim Yeaton* | TITLE: *Executive Director* | (X6) DATE: *09/22/2023*

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 609	Continued From page 1 incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and policy review, the provider failed to report an incident for one of one sampled resident (1) who had a fall with a head injury according to South Dakota Department of Health (SD DOH) guidelines. Findings include: 1. Review of resident 1's medical record, incident report, and investigations from a witnessed fall on 7/9/23 revealed: *She had been on hospice care since 6/27/23. *She had a witnessed fall with head injury on 7/9/23. *A call had been placed by the nursing staff to notify the director of nursing (DON), hospice staff, and the resident's daughter of the fall. *The daughter was informed by the hospice nurse that because the resident was on hospice services treatment costs reimbursement would have been limited. *The hospital emergency department (ED) was called and rather than send her to the ED, the emergency room physican's assistant came to the nursing home and assessed resident 1. *The ED physician's assistant assessed resident 1 and determined she would not require further treatment for the head injury. *The daughter insisted that her mother be sent to the emergency room for evaluation. *An ambulance was then called and transported the resident from the nursing home to the hospital's ED. *Evaluation of the resident had been completed at the ED with the diagnosis of traumatic hematoma of the forehead.	F 609		

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F 609	Continued From page 2 *The resident's fall had not been reported to the SD DOH. *The resident passed away on 7/11/23. Interview on 9/6/23 at 2:00 p.m. with DON A and nurse consultant B regarding not reporting the above incident revealed: *DON A: - Had not thought resident 1's fall had been an incident that should have been reported to the SD DOH [resident with injury that requires transfer for additional care]. -Would not consider a hematoma to have been a serious injury. *Resident 1 had been evaluated by an emergency room physican's assistant who had determined there was no need for further treatment. *Nurse consultant B reported she had not been notified by the staff when the incident ocurred. -If she been contacted she would have advised the staff to report the incident. Review of the provider's revised December 2016 resident fall response policy revealed: *4. a. "If the resident is suspected to have struck their head or the resident was witnessed striking head (regardless if injuries are noted), it is recommended that staff arrange for the resident to be seen by a physician, either in the Emergency Room or physician's office." *"The Community Director consults with the Regional Vice President, Regional Nurse Consultant, and Corporate Compliance to determine further notification needed for: c. Licensing Agency."	F 609		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)	F 657	See next page.	

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F 657	Continued From page 3 §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and policy review, the provider failed to ensure one of one sampled resident (1) had the care plan revised and updated to reflect the following: *Her 7/9/23 witnessed fall. *How to care for her broken left arm which required the use of a sling for immobilization. *Her daughter's request to have been contacted regarding her mother whenever there had been	F 657	1. Resident #1 has been discharged from the facility. All residents have the potential to be affected. 2. The DNS or designee will educate the interdisciplinary team and licensed nurses on appropriate care planning prior to 10/8/23. All staff not in attendance will be educated prior to their next working shift. 3. The DNS or designee will review 4 random resident's medical record and careplan weekly times four weeks and monthly times two months to ensure appropriate care plan interventions are in place. The DNS or designee will bring the results of these audits to the monthly QAPI meeting for further review and recommendation to continue or discontinue the audits.	10/15/23

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F 657	Continued From page 4 any change in her condition or care. Findings include: 1. Review of resident 1's electronic medical record (EMR) revealed she: *Fell on 6/26/23 which resulted in two fractures in her left arm. *Entered hospice care services on 6/27/23. *Had another witnessed fall on 7/9/23. *Expired on 7/11/23. Review of resident 1's 7/11/23 care plan revealed: *No mention of her 7/9/23 fall. *There had been a focus area that stated she had a left arm fracture initiated on 6/27/23 that was not revised to the current status of the resident. -There was an intervention in place to "support injured area with pillow and immobilize part as appropriate" initiated on 6/27/23 and was not revised to reflect the current needs of the resident. with no further instructions or explanation. *There had been no identified problem, goal, or intervention regarding the use of a sling for her fractured left arm. *There was no documentation of instructions on how often the sling was to have been worn or how to use the sling properly. *The care plan had not identified the daughter's preference to have been contacted when there was any change in her condition or care. Interview on 9/6/23 at 10:00 a.m. with certified nursing assistant (CNA) C regarding residents with immobilization devices revealed: *If a resident had a brace or sling it would have been included in the resident's care plan. *Resident tasks to have been completed would have been included on the care plan.	F 657		

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F 657	Continued From page 5 Interview on 9/6/23 with medication aide/CNA F regarding resident care plans revealed: *They knew how to care for residents by checking the care plans. *They were notified of resident changes during the change of shift report along with checking the communication logbook. *Resident tasks to have been completed would have been found in the computer Kardex system. *If a change had been made to the care plan, she thought it would then flow over to the Kardex system. *She was unaware who was responsible to have made changes to the resident care plans. *If the resident had a brace or sling, it would have been listed on the care plan. Interview on 9/6/23 at 1:30 p.m. with CNAs G and H regarding resident care plans revealed: *They both were traveling CNAs. *When they first started employment at the facility they had trained with another CNA for the entire shift. *If they moved to any new or unfamiliar area, they were paired with a CNA for the entire shift. *When asked how they knew how to care for the residents they stated they would look at the computer Kardex. *They thought the resident's care plan would have been reflected in the computer Kardex and if changes were made it would then have been sent to the computer Kardex tasks. *Resident changes would have been reported in a communication book or at the change of shift report. Interview on 9/6/23 at 3:15 p.m. with director of nursing A regarding resident care plans revealed:	F 657		

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F 657	Continued From page 6 *The care plans should include current information regarding the resident care. *Tasks to have been completed by the nursing staff would have been driven by the care plan. *Nursing staff had not made any changes to the care plans because she had not wanted any residents tasks to have been missed. *Updates to the resident care plans should have been made when a resident had changes in care. *Care plans had been revised by herself and the Minimum Data Set (MDS) staff. *She confirmed resident 1's care plan had not included the following: -The fall on 7/9/23. -Information about her use of a sling. -The resident's daughter's close involvement in her care and her preference to have been notified of any changes. *She agreed that it would have been a good idea to include all of the above information. Request was made for the provider's care plan policy but there was no policy.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and policy review, the provider failed to ensure professional standards of practice were followed for one of one sampled resident (1) for failure to: *Provide staff supervision of one of one sampled	F 658	See next page.	

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F 658	Continued From page 7 resident (1) by two of two registered nurses (RN) (E and K) to have prevented her fall on 7/9/23. *Notify her physician and family member of the change in condition on 7/10/23 and obtain new physician orders for continuation of care. *Document the absence of vital signs for her death record. Findings include: 1. Review of resident 1's electronic medical record (EMR) revealed: *On 6/27/23 she was placed on hospice care due to declining health. *She had an unwitnessed fall on 6/26/23. *The resident had been taken by ambulance to the hospital emergency room for evaluation. *Tests conducted revealed she had fractured her left arm in two places. *She had not been a candidate for surgery due to her poor health status. *She stayed in the hospital overnight for observation and returned to the nursing home the next day with a sling on her arm. *A report was completed and sent to the South Dakota Department of Health (SD DOH) for that fall. *The resident had another fall on 7/9/23. Review of resident 1's 7/9/23 fall event investigation report revealed: *RN K had been alerted to the resident's room because she had been calling for help. *When he walked into her room, resident 1 was seated in her recliner and had removed her clothing and the sling from her left arm. *RN K called for assistance from RN E who entered the room and stayed with the resident while he went to get some pain medication for her.	F 658	1. Resident #1 has been discharged from the facility. All residents have the potential to be affected. 2. The DNS or designee will provide education to licensed nursing staff regarding notification to provider, family and/or hospice provider with a change in condition to resident, as well as not pronouncing someone as deceased but rather without the presence of vital signs. The DNS or de-signee will educate all nursing staff on prevention of preventable falls by 10/15/23. All staff not in attendance will be educated prior to their next working shift. 3. The DNS or designee will audit four residents with falls and change in condition weekly times four weeks and monthly times two months to ensure proper notification to family and provider and determine if the fall was preventable. The DNS or designee will audit monthly time 3 months all deaths in the facility to determine if the death was documented appropriately. The DNS or designee will bring the results of these audits to the monthly QAPI meeting for further review and recommendation to continue or discontinue the audits.	10/15/23

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F 658	Continued From page 8 *After RN K administered the pain medication to the resident he noticed she had a soiled brief. *While he walked to the restroom for supplies, he asked RN E to stay next to the resident. *RN E was asked to stay next to the resident by RN K but had left the resident's side and gone to the bathroom to get gloves. *While they were both in the bathroom, they saw the resident fall forward out of the recliner onto her face on the floor. *She was bleeding from the left side of her forehead from a laceration. *RN E and RN K called for help and three CNAs arrived to assist while they assessed the resident and took vital signs. *The DON, hospice staff, and the resident's daughter were notified of the resident's fall. *The resident was then moved into her bed by RN E, RN K, and the CNAs with a mechanical lift. *All staff that had been involved in the incident had been interviewed as a part of the fall investigation. *That fall had not been reported to the SD DOH. Review of resident 1's 7/9/23 event investigation final summary revealed: *"External or environmental risk factors that could have contributed to the event (i.e. side rails, mobility equipment, flooring, lighting, bathroom accommodation, restraints, etc.): Describe. (If yes, did this contribute or cause the event?): -Staff left resident to gather supplies, 1 staff member should have stayed with resident." *"Does the resident take any medication which could have potentially caused or contributed to the event? (Antidepressants, cardiovascular, diuretics, steroids, antianxiety, antipsychotic, hypnotic, anticoagulants, etc.): -Morphine, lorazepam per hospice orders."	F 658		

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F 658	Continued From page 9 *"Any recent medication changes made? Describe changes: (If yes, did this contribute to or cause the event?) -Started on morphine and lorazepam d/t [due to] increased anxiety, behaviors and pain." *"Was the resident experiencing any unstable medical, mood, or behavioral conditions at time of event? (i.e. pain, infection, recent surgery, fracture, elevated bleeding time, URI [upper respiratory infection], LRI [lower respiratory infection], UTI [urinary tract infection], etc.): If yes, describe if this contributed or caused the event: -Increased anxiety and behaviors. Hospice stated she had terminal restlessness." *"Analysis of information, data collection, interviews, reviews of clinical record, etc." -Resident self-transferring when staff had left to gather supplies when resident fell to floor." *"What is the plan to prevent reoccurrence? -Utilize lorazepam and morphine to assist with anxiety and behaviors. Ensure proper positioning prior to leaving residents side, do not leave alone upright in chair." 2. Review of resident 1's EMR revealed: *On 7/9/23, the emergency room physician's assistant (PA) wrote an order for the resident to "remain sitting/sleeping in her chair. Do not place in bed. Keep sling on at all times. May remove for cares, but then needs to be placed back on the patient immediately to [sic] after cares to prevent worsening of swelling in her left arm/hands." *A 7/10/23 nursing note stated: "Resident has increased confusion, asks staff to sleep with her and to kiss her, resident is weak, staff did not attempt to stand resident due to her weakness, resident was incontinent of urine, staff unable to change her as resident cannot stand due to weakness, unable to reposition her to her Lt. [left]	F 658		

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F 658	Continued From page 10 due to pain in her Lt. arm, unable to roll her onto her Rt. [right] side." *Resident 1 had been assisted into her bed by staff who used a mechanical lift. *The night staff had failed to complete the following: -Follow the 7/9/23 physician's order for the resident to remain in her recliner. -Notify the resident's physician, the resident's family, or the hospice staff of her change in condition. -Consult with her physician prior to moving the resident. 3. Continued review of resident 1's EMR revealed: *She had been in hospice services since 6/27/23. *Had a witnessed fall on 7/9/23 which resulted in a traumatic hematoma of her forehead. *She had expired on 7/11/23. *Progress note documented by licensed practical nurse (LPN) I revealed: -Resident passed away at approximately 3:10 a.m. on 7/11/23 with her daughter at the bedside. -Hospice, hospital, and funeral home were notified. -Resident's postmortem care was performed by a certified nursing assistant (CNA). -Director of nursing (DON) A and administrator J had been notified of the resident's death. Interview on 9/6/23 at 2:00 p.m. with DON A regarding pronouncing the death of a resident revealed: *Licensed nurses would have documented the absence of respirations and apical heartbeat. *Documentation of the name of the physician notified when all vital signs ceased. *She agreed that the above documentation had	F 658		

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F 658	Continued From page 11	F 658		

not provided any vital signs or the name of the physician contacted.

Review of the provider's undated procedure for death of a resident revealed "when all vital signs ceased, chart which doctor was notified."

Further interview on 9/6/23 at 2:00 p.m. with DON A regarding resident 1's 7/9/23 fall and transferring from her recliner to the bed revealed:
*Both RN E and RN K thought the 7/9/23 fall could have been avoided.
*She would have expected one of the staff to stay next to the resident to ensure her safety.
*She agreed the fall could have been prevented.
*On 7/10/23 the nurse on duty made the decision that the resident would have been more comfortable in her bed and could have been cared for with less pain if she was in her bed.
*It had been in the middle of the night when the resident was moved to her bed.
*The nursing staff would not usually call in the middle of the night for notifications to family or the physician for a resident's change of condition.
*She confirmed there had been no documentation to show the physician had been called regarding her change in condition.
*The daughter of resident 1 had come the next morning and was upset that she had not been notified that her mother had been moved to her bed.
*She agreed that it would have been good to call the resident's daughter when the resident had been moved to her bed because there had been a history of the daughter being closely involved with her mother's care.
*She confirmed the daughter had been upset on another occasion when she had been notified her mother's sling was removed by the night shift

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW HEALTHCARE CENTER	611 EAST 2ND AVE FLANDREAU, SD 57028

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 12 staff between the evening of 7/7/23 and the morning of 7/8/23 and put into her bed rather than remain in her recliner. -The nursing staff that had taken her sling off and put her into bed had worked only one time a month. -That had been the only other time the resident had been put into her bed instead of being left in her recliner. *She would have expected the nursing staff to follow physician's orders. *Agreed there had been no documentation a new order had been obtained later from the physician for her continued care. Request was made for the provider's notification policy for change of condition but one had not been provided prior to exit.	F 658		